# Kentucky Transitions Assessment

## Face Sheet

Individual_____ Date of Birth____/____/____
Facility_____ SS#_____
Admit Date_____/_____/_____ Medicaid #_____
Address_____ Medicare #_____
Phone_____
Marital Status: ()M ()W ()D ()S
Spouse:_____ Advanced Directives Y____ N_____
Guardian/POA:_____ Attached: Y____ N_____
Address:_____ Type:_____
Adjudicated Y_____ N_____

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## Contact Information

Community Contacts:

- Regional Team/Phone:_____
- Residential Provider/Phone:_____
- Residential Provider/Phone:_____
- Day Service Provider/Phone:_____
- Comprehensive Care Spec/Phone:_____
- Physician/Phone:_____
- Pharmacy/Phone_____
- Hospital/Phone:_____

Facility Contacts:

- Transition Facilitator:_____
- Administrator:_____
- Behavior Analyst:_____
- Physician:_____
- Psychiatrist:_____
- Other Medical:_____
- Other Medical:_____
- Other Medical:_____

Diagnosis: _____ _____
_____ _____
_____ _____
_____ _____

For after-hours support, please call (XXX) XXX-XXXX, ask for Administrator on Duty

**1. Financial: Current or anticipated income:**

A. Type of Income:

- ☐ SSI _____
- ☐ SSDI _____
- ☐ SS Retirement _____
- ☐ Salary _____
- ☐ Employee Retirement _____
- ☐ Other

Total (Gross Amount):_____

B. Type of Assistance:

- ☐ Guardian Needed/Available Name_____
- ☐ SSA payee Needed/Available Name_____

C. Type of Service:

- ☐ Bank Account Needed/Available Provider_____
- ☐ Bill Payer Service Needed/Available Provider_____
- ☐ Direct Deposit Needed/Available Provider_____

**2. Family/Friends/Advocates:**

Name/Relationship_____
Address/Phone_____

Name/Relationship_____
Address/Phone_____

Name/Relationship_____
Address/Phone_____

Name/Relationship_____
Address/Phone_____

**Facility Information:**

Facility Name:_____
Address:_____County:_____
Phone:_____ Contact Person/Title:_____

Physician:_____Phone:_____
Address:_____License # (5 digits):_____

**Please list any acute care, nursing, or ICF/MR/DD admissions, in the past 12 months:**

| Facility | Admission Date//Discharge Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Reason for Entering Facility:**

- ☐ Treatment for a medical condition.
- ☐ Health or personal are problems while in community.
- ☐ Unable to return home from hospital/rehabilitation/facility.
- ☐ Difficulty in maintaining community residence.
- ☐ Other:_____

Comments:_____

_____

**A. Condition**:

- ☐ Improved
- ☐ Receiving treatment
- ☐ Duration of treatment
- ☐ Expected results
- ☐ Additional treatment necessary before transition to community?

Describe:_____

Comments:_____

_____

**B. Health problems** while in community:

- ☐ Family/Friends unable able to provide care.
- ☐ Shortage of good attendants.
- ☐ High cost of paying attendants.
- ☐ Lack of medical/nursing/therapy services.
- ☐ High cost of medical/nursing/therapy services.
- ☐ Change in health condition.
- ☐ No one to contact in case of emergency.
- ☐ Frequent illness/hospitalization.
- ☐ Specific medical condition, (stroke, heart attack, diabetes, dementia, etc.)

  Describe condition(s):_____
- ☐ Other:_____

Comments:_____

C. **Reason(s) u*nable to return home*** from hospital/rehabilitation/facility:

- ☐ Family/friends unable to provide care.
- ☐ Shortage of good attendants.
- ☐ High cost of paying attendants.
- ☐ Lack of medical/nursing/therapy services.
- ☐ High cost of medical/nursing/therapy services.
- ☐ High cost of rent or bills.
- ☐ Home modifications needed.
- ☐ Adaptive aids or mobility device needed.
- ☐ Inadequate transportation.
- ☐ Other:_____

Comments:_____

**D. Difficulty in maintaining community residence**:

- ☐ No services to help maintain house of apartment.
- ☐ No services to help with money management or decision-making.
- ☐ Family/Friends concerned about safety.
- ☐ High cost of rent or bills.
- ☐ Needed home modification.
- ☐ Needed adaptive aids of mobility device.
- ☐ Other:_____

Comments:_____

## Psychosocial Self Assessment:

**Community Inclusion**: What do you like to do and where would you like to go in the community? Where do you go for recreation? Is there somewhere you would like to go but are unable?

_____
_____
_____

**Relationships:** How do you stay in contact with your friends and family? Do you need assistance in making/keeping friends? Who are your friends?

_____
_____
_____
_____

**Rights:** Do you understand your rights? Do you feel your rights are restricted? Do you know what abuse is? Do you know what neglect is?

_____
_____
_____
_____

**Dignity and Respect**: How are you treated by staff? Do you have a place you can go to be alone or have privacy? Do you have a private place you can go to be with friends?

_____
_____
_____
_____

**Health:** Who are your doctors? Do you have any health concerns? What medications do you take? How do your medications make you feel?

_____
_____
_____
_____

**Lifestyle:** Do you have a job? Do you want to work? Do you want to go to school? Are you able to go to the bank? Do you have spending money to carry? Are you able to access your money as needed?

_____
_____
_____
_____

**Satisfaction with supports**: Are you satisfied with your services and supports? What do you like about them? What changes would you like to see? Do you feel you have choices about what you can do? Are you happy with your life? What parts of your life are you happy about? What parts are you unhappy about?

_____
_____
_____
_____

| **ACTIVITIES OF DAILY LIVING/PHYSICAL FUNCTIONING** | |
|---|---|
| Independent: | No set up or physical help required. |
| Supervision: | Oversight, encouragement, or cueing needed. Set-up needed. |
| Physical Assist: | Person highly involved in activity. Requires physical help in guided maneuvering of limbs, or other non-weight-bearing assistance. |
| Extensive Assist: | Ability to participate is significantly limited. Requires weight-bearing support and/or hands-on assist during task. |
| Dependent: | Unable to participate to any significant degree, requires total assist to complete task. |

**A. Bed Mobility: How person moves to and from lying position, turns side to side, and positions body while in bed.**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent

Comments:_____
_____

**B. Transfer: How person moves between surfaces, to and from bed, chair, wheelchair, standing position, (excluding to/from bath or toilet).**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent

Comments:_____
_____

**C. Ambulation: How person moves from one location to another. Includes mobilizing by wheelchair, once in the chair.**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent

Comments:_____
_____

**D. Dressing: How person puts on/fastens/takes off all items of clothing, including prosthesis.**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent
- ☐

Comments:_____
_____

**E. Eating: How person eats and drinks. Includes intake of nourishment by other means, (tube feeding, total parenteral nutrition/TPN).**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent
- ☐

Comments:_____
_____

**F. Toilet Use: How person uses toilet room, (or commode, bedpan, urinal), transfers on/off toilet, cleanses self, changes pads/briefs, manages ostomy or catheter, adjusts clothing.**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent

Comments:_____
_____

**G. Personal Hygiene/Grooming(excludes baths/showers): How person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing/drying face, hands and perineum.**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent

Comments:_____
_____

**H. Bathing: How person takes a full-body bath/shower or sponge bath, excluding washing of back or hair. Includes transfers into/out of tub/shower.**

- ☐ Independent
- ☐ Supervision
- ☐ Physical Assist
- ☐ Extensive Assist
- ☐ Dependent

Comments:_____
_____

**I. Continence:**

| **Bladder** | **Bowel** | |
|---|---|---|
| _____ | _____ | **Continent:** Complete control, includes use of indwelling urinary catheter or ostomy device that does not leak or stool. |
| _____ | _____ | **Usually Continent**: Incontinent less than once weekly. |
| _____ | _____ | **Occasionally Incontinent**: Incontinent more that twice weekly, but not daily. |
| _____ | _____ | **Frequently Incontinent:** Incontinent more than three times weekly, but some control present. |
| _____ | _____ | **Incontinent:** Multiple daily episodes of incontinence. |

**J. Continence Appliances and Programs:**

- ☐ Any scheduled toileting plan
- ☐ Bladder retraining
- ☐ External condom catheter
- ☐ Indwelling urinary catheter
- ☐ Intermittent catheterization
- ☐ Pads/Briefs used
- ☐ Enemas/Irrigations
- ☐ Ostomy present
- ☐ Specialized genital and/or urinary care

Comments:_____
_____

## INSTRUMENTAL ACTIVITIES OF DAILY LIVING

**A. Meal Preparation:**

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Arranges for meal preparation
- ☐ Requires assistance with meal preparation
- ☐ Requires total meal preparation

Comments:_____
_____

**B. Shopping:**

- ☐ Independent
- ☐ Requires Supervision or verbal cues
- ☐ Requires assistance with shopping
- ☐ Able to make list of needed items, arrange for pick-up/delivery
- ☐ Unable to participate in shopping

Comments:_____
_____

**C. Housekeeping** (Sweeping, dishwashing, dusting, etc.):

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Requires assistance with light housekeeping
- ☐ Arranges for light housekeeping duties to be performed
- ☐ Unable to perform/participate in light housekeeping

Comments:_____
_____

**D. Housework:** (Mopping, heavy cleaning, vacuuming, washing windows. etc.):

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Requires assistance with heavy housework
- ☐ Arranges for heavy housework to be performed
- ☐ Unable to perform/participate in heavy housework

Comments:_____

_____

**E. Laundry**

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Requires assistance with laundry task
- ☐ Arranges for laundry to be done
- ☐ Unable to perform/participate in any laundry task

Comments:_____

_____

**F. Medications: Person's ability to plan/arrange for pick-up, delivery, or some means of gaining possession of medication <u>and taking medication correctly.</u>**

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Requires assistance in obtaining and/or taking medication correctly
- ☐ Arranges for medication to be obtained and taken correctly
- ☐ Unable to participate in obtaining medication and/or taking as correctly.

Comments:_____

_____

**G. Finances**

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Requires assistance with handling finances
- ☐ Arranges for someone to handle finances
- ☐ Unable to participate in handling finances

Comment:_____

_____

**H. Telephone**

- ☐ Independent
- ☐ Requires supervision or verbal cues
- ☐ Requires adaptive device to use telephone
- ☐ Requires assistance when accepting/making calls
- ☐ Unable to use telephone

Comments:_____

_____

## NEURO/EMOTIONAL.BEHAVIORAL

**A. Behavior:** Check all that apply. Describe behaviors in comment section below.

- ☐ No behavior challenges
- ☐ Disruptive
- ☐ Self-Injurious
- ☐ Agitated
- ☐ Self-Neglecting
- ☐ Assaultive

Comments:_____
_____
_____

**B. Orientation**

- ☐ Oriented to Person / Place / Time
- ☐ Forgetful
- ☐ Confused
- ☐ Impaired judgment
- ☐ Unresponsive

Comments:_____
_____
_____

**C. Has person experienced a major life change or crises in past twelve months?**

- ☐ Yes
- ☐ No

Describe:_____
_____
_____

**D. Is person actively participating in social and/or community activities?**

- ☐ Yes
- ☐ No

Describe:_____
_____
_____

**E. Is person experiencing any of the following?** Explain frequency/details in the comment section:

- ☐ Difficulty recognizing others
- ☐ Loneliness
- ☐ Sleeping problems
- ☐ Anxiousness
- ☐ Lack of interest
- ☐ Suicidal behavior/verbalization
- ☐ Memory Loss: ____Short-Term _____Long Term
- ☐ Irritability
- ☐ Alcohol abuse
- ☐ Medication abuse
- ☐ Substance abuse
- ☐ Hopelessness

Comments:_____
_____
_____
_____

**F. Cognitive Functioning:** Person's current level of alertness, orientation, comprehension concentration, and immediate memory, ability to recall simple commands.

- ☐ Alert/Oriented, able to focus and shift attention, comprehends and recalls tasks directions independently.
- ☐ Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ Requires assistance and some direction in specific situations (on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
- ☐ Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ Totally dependent due to disturbance such as constant disorientation, coma, persistent vegetative state, or delirium.

Comments:_____
_____
_____

**G. Confusion** (reported or observed**)**:

- ☐ Never
- ☐ In new or complex situations only
- ☐ On awakening or at night only
- ☐ During the day and evening, but not constantly
- ☐ Constantly
- ☐ NA (non-responsive

Comments:_____
_____

**H. Anxiety** (reported or observed)

- ☐ None of time
- ☐ Less often than daily
- ☐ Daily but not constantly
- ☐ All of the time
- ☐ NA (non-responsive)

Comments:_____

_____

**I. Depressive Feelings?** (reported or observed)

- ☐ Depressed mood (feeling sad, tearful)
- ☐ Hopelessness
- ☐ Sense of failure or self-reproach
- ☐ Recurrent thought of death
- ☐ Thoughts of suicide
- ☐ None of the above feelings reported or observed

Comments:_____

_____

**J. Challenging Behaviors** (reported or observed)

- ☐ Indecisiveness, lack of concentration
- ☐ Sleep disturbances
- ☐ Diminished interest in most activities
- ☐ Recent changes in appetite or weight
- ☐ Agitation
- ☐ Suicide attempt
- ☐ None of the above behaviors observed or reported

Comments:_____

_____

**K. Behaviors demonstrated at least once per week:**

- ☐ Memory Deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required.
- ☐ Impaired decisions-making: failure to perform usual ADLs, inability to appropriately stop activities, jeopardizes safety through actions.
- ☐ Verbal disruptions: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ Physical aggression: aggressive or combative to self and/or others, (hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects).
- ☐ Disruptive, infantile, or socially inappropriate behavior, (excludes verbal actions)
- ☐ Delusional, hallucinatory, or paranoid behavior.
- ☐ None of the above behaviors demonstrated.

Comments:_____

_____

_____

_____

**L. Frequency of Behavior Problems:** (reported or observed) such as wandering episodes, self abuse, verbal disruption, physical aggression, etc.

- ☐ Never
- ☐ Less than once per month
- ☐ Once per month
- ☐ Several times per month
- ☐ Several times per week
- ☐ At least daily

Comments:_____

_____

**M. Mental Status**

- ☐ Oriented
- ☐ Forgetful
- ☐ Depressed
- ☐ Disoriented
- ☐ Lethargic
- ☐ Agitated
- ☐ Other (describe in comments below)

Comments:_____

_____

**N. Is person receiving Psychiatric Nursing Services?**

- ☐ yes
- ☐ No

Comments:_____

## CLINICAL INFORMATION

**A. Vision**

- ☐ Vision adequate (with/without corrective lens)
- ☐ Difficulty seeing print
- ☐ Difficulty seeing objects
- ☐ No useful vision

Comments:_____

**B. Hearing**

- ☐ Hearing adequate (with/without hearing aid)
- ☐ Difficulty with conversation level
- ☐ Able to hear only loud sounds
- ☐ No useful hearing

Comments:_____

**C. Communication**

- ☐ Able to communicate needs
- ☐ speaks with difficulty by can understand
- ☐ Uses sign language and/or gestures, communication device
- ☐ Inappropriate context
- ☐ No useful hearing

Comments:_____

**D. Diet**

- ☐ Maintains an adequate diet
- ☐ Uses dietary supplements
- ☐ Refuses to eat
- ☐ Forgets to eat
- ☐ History of choking, difficulty swallowing
- ☐ Requires special diet (low salt, low fat, etc.)
- ☐ Tube feeding required (brand, amount, frequency in comments below)
- ☐ Other dietary considerations (describe in comments below)
- ☐ Weight loss/gain in last 6 months Current weight_____

Comments:_____

**E. Respiratory Care/Equipment needed?**

Check appropriate respiratory interventions, enter specific information in comment section below;

- ☐ No interventions required
- ☐ Oxygen therapy (liters per minute_____ and delivery device_____)
- ☐ Nebulizer (breathing treatments)
- ☐ Management of respiratory infection
- ☐ Nasopharyngeal airway
- ☐ Tracheotomy care
- ☐ Suction
- ☐ Aspiration Precaution
- ☐ Pulse Oximetry
- ☐ Ventilator (list settings below)

Comments:_____

**F. Stroke**; Does person have history of stroke (CVA) or Transient Ischemic Attack (TIA)?

- ☐ No
- ☐ Yes (date(s)_____)
- ☐ Residual physical injury
- ☐ Swallowing impairment
- ☐ Memory impairment
- ☐ Speech impairment
- ☐ Weakness (extremities affected_____)
- ☐ Paralysis (extremities affected _____)

Comments:_____

**G. Cardiac History**

- ☐ None
- ☐ Heart attack
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Other

Comments:_____

**H. Skin condition**

- ☐ No abnormalities or problems noted/reported
- ☐ Abnormal color (flushed, pale)
- ☐ Requires ointments/lotions
- ☐ Requires simple dressing changes (band-aids, occlusive dressing)
- ☐ Requires complex dressing changes (sterile, irrigation, packing, measurements)

Comments:_____
_____

**I. Oral/Dental**

- ☐ Dentures ____full or ____partial
- ☐ Braces
- ☐ Crowns
- ☐ Implants
- ☐ Teeth/gums in poor condition, caries, broken teeth, etc.

Comments:_____
_____

**J. Movement/Motor Control:** (identify location of impairments)

- ☐ Able to move independently
- ☐ Balance/history of falls
- ☐ Paralysis_____
- ☐ Hand dexterity/weakness _____
- ☐ Amputation _____
- ☐ Contractures_____
- ☐ Spasm(s) _____
- ☐ Tremor(s)_____

Comments:_____
_____

**K. Does person require assistance with changes in body positioning?**

- ☐ No assistance required
- ☐ To maintain proper body alignment
- ☐ To prevent further deterioration of muscle/joints/skin
- ☐ To manage pain
- ☐ To maintain/protect skin integrity

Comments:_____
_____

**L. Does person require 24 hour caregiving/monitoring?**

- ☐ Yes
- ☐ No

Comments: (include skill level, natural supports available):_____
_____

**M. Does person require respite services?**

- ☐ Yes
- ☐ No

Comments: (include frequency, skill level):_____
_____

**N. Monitoring indicated**. Note frequency of monitoring, indicate those ordered by physician.

- ☐ Labs:_____
- ☐ Vital Signs:_____
- ☐ Weights:_____
- ☐ Monitoring for specific conditions as listed below:

_____

**O. Intravenous fluids, medication, alimentations**:

**Peripheral IV**:

- ☐ Solution:_____
- ☐ Amount/Dosage:_____
- ☐ Rate:_____
- ☐ Frequency:_____
- ☐ Prescribing Physician:_____

**Central Line/PICC:**

- ☐ Solution:_____
- ☐ Amount/Dosage:_____
- ☐ Rate:_____
- ☐ Frequency:_____
- ☐ Site Care:_____
- ☐ Prescribing Physician:_____

Comments:_____
_____
_____

## Medication Administration

(See MAR for current administration purpose)

| MEDICATION/ DOSE | Frequency | Route of Administration | Purpose | Prescribing Physician | Who can give medication |
|---|---|---|---|---|---|
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*Side effect(s) provided on separate document.

**This form is meant only as a listing of the most recent medications and doses, and is not a tool for dispensing or administering medications. Medication(s) should be monitored based on current prescriptions.

## ASSISTIVE TECHNOLOGY
**Check all that apply**

| Mobility | Available | Needed | Repair/Replace |
|---|---|---|---|
| Power Wheelchair | | | |
| Shower Chair | | | |
| Shower Bench | | | |
| Brace | | | |
| Prosthesis (type_____) | | | |
| Cane, Walker, Crutch | | | |
| Transfer Equipment | | | |
| Lifting Chair | | | |
| Other: | | | |

| Bed | Available | Needed | Repair/Replace |
|---|---|---|---|
| Regular | | | |
| Semi-automatic | | | |
| Fully-automatic | | | |
| Therapeutic Mattress | | | |
| Other: | | | |

| Mobility | Available | Needed | Repair/Replace |
|---|---|---|---|
| Power Wheelchair | | | |
| Shower Chair | | | |
| Shower Bench | | | |
| Brace | | | |
| Prosthesis (type_____) | | | |
| Cane, Walker, Crutch | | | |
| Transfer Equipment | | | |
| Lifting Chair | | | |
| Other: | | | |

| Eating Utensils | Available | Needed | Repair/Replace |
|---|---|---|---|
| IV/TPN Supplies | | | |
| Modified Utensils | | | |
| Tube Feed Supplies | | | |
| **Vision** | **Available** | **Needed** | **Repair/Replace** |
| Glasses | | | |
| Contact Lenses | | | |
| Magnifier | | | |
| | | | |
| Other: | | | |
| **Cognitive/Memory** | **Available** | **Needed** | **Repair/Replace** |
| Planner/Organizer | | | |
| Programmable Watch | | | |
| Medication Dispenser | | | |
| Door Locks/Alarms | | | |
| | | | |
| Other: | | | |
| **Communication** | **Available** | **Needed** | **Repair/Replace** |
| Hearing Aid | | | |
| TTY Device | | | |
| Modified Phone | | | |
| Commercial Device | | | |
| Computer/Internet Access | | | |
| Communication Board | | | |
| Voice Amplifier/Tool | | | |
| | | | |
| Other: | | | |
| **Medical Alert** | **Available** | **Needed** | **Repair/Replace** |
| Bracelet/Tags: | | | |
| Other: | | | |

## INVENTORY OF COMMUNITY SERVICES AND SUPPORT NEEDS

**1. Living Arrangement**; List preference:
(Enter #1 for first choice, #2 for second choice, etc)

____ Alone in your home or apartment
____ Live with family
____ Live with friend(s)
____ Assisted Living facility
____ Foster Care or Alternative Family Placement
____ Would like to have room/mate
____ Other_____

Comments:_____

**2. Desired Location** (City/County):_____

**3. Accessibility Requirements**; Check all that apply:

- ☐ Widened Doorways
- ☐ No Step Entrance
- ☐ No Stairs
- ☐ Bathroom Handrails
- ☐ Roll-in Shower
- ☐ Automatic Door Opener
- ☐ Environmental Control System
- ☐ Entrance Ramp
- ☐ Wheelchair Accessible Kitchen
- ☐ First-Floor Apartment
- ☐ Curve Cut
- ☐ Other:_____

Comments:_____

**4. Require location within Public Transit Service area?**

- ☐ Yes
- ☐ No

Comments:_____

**5. Desired Provider(s):**

_____
_____
_____

**6. If living arrangements have been identified:**
**(***check all that apply and enter information, including name, telephone number, etc.)*

- ☐ With other person:
  - Relationship:_____
  - Name/Address:_ _____
  - Phone(s):_____

- ☐ Independent Residence_____
  - Address:_____
  - Contact person:_____

- ☐ Foster Care
  - Name/Address:_____
  - Phone:_____

- ☐ Assisted Living Facility
  - Name/Address_____
  - Contact person/Phone_____

- ☐ Other:_____

**7. Check all that apply and enter information:**

**Type of Residence**:

- ☐ House
- ☐ Apartment
- ☐ Guest House
- ☐ Other_____

**Status**:

- ☐ Room Available
- ☐ Agreement in place
- ☐ Will pay rent
- ☐ Will share rent with room/mate

**Condition:**

Modification needed:

_____
_____
_____

Repair/Renovation needed:

_____:_____
_____
_____

**8. What is the guardian's/family preference for living arrangement for this person?**

_____

**9. Documentation of referral to Ky Housing Transition Team,** (date, team member contacted, etc):

_____
_____
_____
_____

**EMPLOYMENT:** The ability to function at a job site. This question concerns the need for employment related assistance, addressing job coach duties.

**1. Current volunteer or status and interest:**

- ☐ Retired
- ☐ Not employed
- ☐ Volunteering
- ☐ Employed full time
- ☐ Employed part time
- ☐ Interested in obtaining or changing job
- ☐ Not interested in obtaining or changing job

Comments:_____

**2. Current employment:**

- ☐ Attends pre-vocational day activity/work activity program
- ☐ Attends sheltered workshop
- ☐ Has a paid job in community
- ☐ Works at home

Comments:_____

**3. Assistance needed to work;** (optional for unemployed persons):

- ☐ Independent (with assistive devices if applicable)
- ☐ Needs help weekly or less (e.g., if problem arises)
- ☐ Needs help every day but does not need continuous presence of another
- ☐ Needs the continuous presence of another

Comments:_____

## TRANSPORTATION

**1. Type:**

- ☐ Fixed bus route
- ☐ Para-transit
- ☐ Family members/friends
- ☐ Taxi
- ☐ Ambulance/Transportation company
- ☐ Other/Not sure

Comments, including the consistent availability of identified transportation resources:

_____
_____

**2. Assistance needed**; check all that apply:

- ☐ Training for fixed route buses
- ☐ Establishing eligibility for Para-transit
- ☐ Transferring in/out of vehicles
- ☐ Escort
- ☐ Locate medical transportation
- ☐ Locate non-medical transportation
- ☐ Orientation and Mobility Training
- ☐ Drive own car

Comments:_____
_____

Please describe in detail any information regarding health, safety, and welfare/crisis issues:

## AVAILABLE SUPPORT

1. Name:_____
   Age/Relationship_____
   Is this person functionally able to provide care?_____
   Care provided/frequency:_____
   Comments:_____
   _____
   _____

2. Name:_____
   Age/Relationship_____
   Is this person functionally able to provide care?_____
   Care provided/frequency:_____
   Comments:_____
   _____
   _____

3. Name:_____
Age/Relationship_____
Is this person functionally able to provide care?_____
Care provided/frequency:_____
Comments:_____
_____
_____

4. Name:_____
Age/Relationship_____
Is this person functionally able to provide care?_____
Care provided/frequency:_____
Comments:_____
_____
_____

| COMMUNITY / INFORMAL / FAMILY SUPPORTS | | | |
|---|---|---|---|
| "X" = supports to be provided by family. | Supports | Confirmed Yes - No | Comments |
| | Guardianship | | |
| | Transportation | | |
| | Personal Care | | |
| | Furniture | | |
| | Home Maintenance | | |
| | Financial Management | | |
| | Personal Care Management | | |
| | Health Management | | |
| | Home Management | | |
| | Household Items | | |
| | Nursing Assistance | | |
| | Shopping | | |

| COMMUNITY SUPPORTS | | | |
|---|---|---|---|
| "X" = supports to be provided by family. | Supports | Confirmed Yes - No | Comments |
| | Meal Delivery | | |
| | Food Banks | | |
| | Food Stamps | | |
| | Medicaid Card | | |
| | Grocery Delivery | | |
| | Discount Phone Service | | |
| | Clothing | | |
| | Home Furnishings | | |
| | Family plans to subsidize | | |
| | Communications Equipment | | |
| | Counseling / Support Groups | | |
| | Family Counseling | | |
| | Place of Worship | | |
| | Senior Center | | |
| | IL / ADL Skills | | |
| | Medical / Personal Care | | |
| | Money Management | | |
| | Other: | | |

Comments:_____
_____
_____
_____

| COMMUNITY SUPPORTS | | | |
|---|---|---|---|
| "X" = Services to be received | Support Services | Confirmed Yes - No | Potential Provider |
| | Nursing / Therapies | | |
| | Recreation | | |
| | ERS | | |
| | Day Program | | |
| | Guardianship | | |
| | Transportation | | |
| | Personal Care | | |
| | Furniture | | |
| | Household Items | | |
| | Moving Assistance | | |
| | SSA payee | | |
| | Financial Management | | |
| | Personal Care Management | | |
| | Health Management | | |
| | Home Maintenance | | |
| | Shopping | | |
| | Household Items | | |
| | Moving Assistance | | |
| | | | |
| | | | |

Community / Family Supports - General Comments:_____
_____
_____
_____
_____
_____
_____
_____

## ACTIVITIES / SOCIAL ENVIRONMENT

1. Activity participation:
   - ☐ Primarily solitary
   - ☐ Primarily with friends/family
   - ☐ Primarily with groups/club
   - ☐ Other:_____
   - ☐ Unknown

2. How often does the individual go out of the house/building to activities?
   - ☐ Daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Seldom
   - ☐ Never
   - ☐ Unknown

3. How often does the individual have telephone contact with others?
   - ☐ Daily
   - ☐ Weekly
   - ☐ Monthly
   - ☐ Seldom
   - ☐ Never
   - ☐ Unknown

4. Does the individual have someone to talk to about problems/confide in?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

5. Does the individual have a close personal relationship?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

6. Will the relationship be affected by the individual's move?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

7. Are pets important to this individual?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

8. Do pets need to be considered in care planning?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

9. Is religion important to this individual?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown

10. Religious affiliation:_____

General Comments:_____
_____
_____
_____
_____
_____
_____

## SIGNATURE PAGE

**Signature of Transition Team member**

Completed by:_____Date____/____/____
Title:_____Phone_____

Additional/General comments:_____
_____
_____

**Statement of Interest:**

- ☐ I participated in completing this Kentucky Transitions Assessment Form.

- ☐ I choose to pursue opportunities to transition to a community living arrangement.

OR

- ☐ I choose NOT to pursue opportunities to transition to a community living arrangement.

- ☐ Even though I am choosing to pursue transition to community living, I understand there is no guarantee that I will be transitioned.

***Signature*** _____Date____/____/____
____Consumer ____Parent/Guardian ____Other Legal Representative

Print Name_____Phone:_____
*(Additional signatures on next page if needed)*

**Comments:** (Agree / Disagree / Explain) _____
_____
_____
_____

***Signature*** _____Date____/____/____
____Consumer ____Parent/Guardian ____Other Legal Representative

Print Name_____Phone:_____
*(Additional signatures on next page if needed)*

**Comments:** (Agree / Disagree / Explain) _____
_____
_____
_____

***Signature***_____Date____/____/____
____Consumer ____Parent/Guardian ____Other Legal Representative

Print Name_____Phone:_____
*(Additional signatures on next page if needed)*

**Comments:** (Agree / Disagree / Explain) _____
_____
_____
_____
_____
_____

**Additional Information:**